Barton Community Health Center

Patient Information							
First	Middle	Last	Race	Social Security Number		Birth Date	Sex
Mailing Address				City/State		Zip Code	
Physical Address				City/State		Zip Code	
Home Phone	Mobile Phone	Work Phone			Marital Status	Religion	
Employer Name	Employer Address				City/State/Zip		
Employment title			Employment Status Please Circle One				
			Retired	None	Disabled	FT	PT	Casual

Emergency Contact		
Name	Address:	City/State zip:
Relationship:	Home Phone:	Mobile Phone:

Insurance Information			
Primary Insurance Name		ID number	Group Number
Insured Name (If insured through spouse, parent, etc.)			Date of Birth
Relationship to patient		Sex	Social Security Number
Employer Name/Address/Phone			
Secondary Insurance Name		ID number	Group Number
Insured Name (If insured through spouse, parent, etc.)			Date of Birth
Relationship to patient		Sex	Social Security Number
Employer Name/Address/Phone			

Staff Use Only - Does the patient have an advanced directive? _____ Yes _____ No

Patient requests more info? _____ Offered _____ Refused _____ Accepted

OFFICE POLICY: I understand and agree to the following rules set forth by Barton Health:

1.) Payment is required at the time of service. If I cannot pay my co-payment, my appointment will be rescheduled.

2.) If I have not checked in for my appointment, by my scheduled appointment time, my appointemnt will be rescheduled.

FINANCIAL AGREEMENT AND AUTHROIZATION FOR TREATMENT:

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees and such other costs as the court determines proper. I hereby assign all proceeds of insurance to this office (a copy of this assignment is as valid as the original.) I authorize the release of all medical information necessary to process any claims on my behalf. I also request payment of medical and/or government benefits to this office.

_____ _____

Patient/Responsible Party Signature DATE